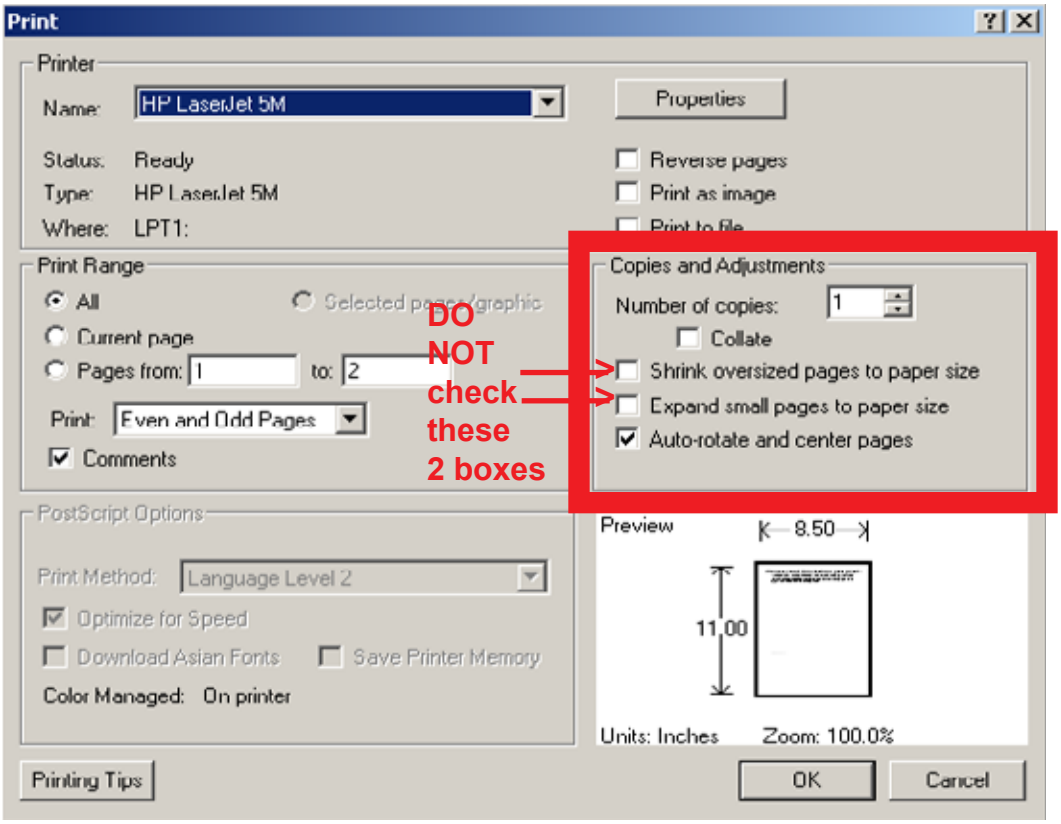
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Hearing Instrument Fitter/Dispenser License Application Packet

1. 654-014 ... Printing Instructions/Contents List/SSN Information/Deposit Slip ..... 2 pages
2. 654-032 ... Hearing Instrument Fitter/ Dispenser Application Instructions ..... 2 pages
3. 654-002 ... Application for Hearing Instrument Fitter/ Dispenser ..... 4 pages
4. 654-023 ... Out of State Verification of Certification/Licensure as a Hearing Instrument Fitter/Dispenser ..... 1 page
5. 654-037 ... Special Examination Requirements ..... 1 page
6. I.I.H.I.S..... Application for Hearing Instrument Fitter/Dispenser Examination ..... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Hearing Instrument Fitter/Dispenser

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 654-014 (REV 4/2006)

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Washington State Department of Health

Hearing Instrument Fitter/Dispenser Application Instructions

Applicants must meet the following requirements:

Licensure
Successful completion of a minimum of a two-year degree program in hearing instrument fitter/dispenser instruction.
Successful completion of Hearing Instrument Fitter/Dispenser Examination.
Completion of a minimum of four clock hours of AIDS/HIV education.

Licensure

The application must be completed and include the following documentation and information:

- Please type or print clearly on all application forms. Be aware that your application is a public record and may be released upon written request.

  Note: The address entered on the application form is your address of record. All correspondence will be sent to this address and it will appear on your license;

- Official transcripts providing proof of successful completion of a minimum of a two-year degree program in hearing instrument fitter/dispenser instruction at a Board-approved program.

  Board-approved programs:

  Spokane Falls Community College

  Bates Technical College

- Successful completion of the State hearing Instrument Fitter/Dispenser examination.

  Note: The required examination is the International Institute for Hearing Instrument Studies Licensing Examination. This exam is administered by the International Hearing Society. The enclosed Application for Hearing Instrument Fitter/Dispenser Examination must be completed and sent directly to:

  International Institute for Hearing Instrument Studies
  16880 Middlebelt Road Suite 4
  Livonia, MI 48154

OR

Continued on Back

Hold a current valid license from another jurisdiction, providing the standards of licensing for the other jurisdiction are substantially equivalent to those in Washington State. Applicants who are currently or have been licensed in another state or jurisdiction must complete the upper portion of the Out of State Verification of Licensure form. Forward the form to the jurisdiction of licensure or certification for completion of the remainder of the form. The licensing agency may then forward the form to the Department of Health, Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869.

- Completion of a minimum of four clock hours of AIDS education.
- The following fees must accompany the applications:

  Application fee $125.00 + license fee $100.00 = **$225.00**

  Please make check or money order payable to the Department of Health.

  Note: Application for examination is due 45 days prior to the date of the examination.

Completed application, supporting documentation and fees are to be submitted to:

Department of Health
Hearing and Speech Program
PO Box 1099
Olympia, WA 98507-1099

If you have any questions please call, (360) 236-4700.

Note: Every individual engaged in the fitting and dispensing of hearing instruments shall carry a surety bond in the sum of ten thousand dollars ($10,000). Please refer to RCW 18-35.240.

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
VALIDATION	DATE RECEIVED
LICENSE #	ISSUANCE DATE

LICENSE #

Application For Hearing Instrument Fitter/Dispenser

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)	MAIDEN NAME
☐ Female ☐ Male			

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If presently employed by a Fitter/Dispenser or Licensed Audiologist, please provide the following:

BUSINESS NAME

ADDRESS

CITY	STATE	ZIP	COUNTY

2. License Applying For:

Please indicate which of the following you are applying for:

☐ Hearing Instrument Fitter/Dispenser License

☐ Hearing Instrument Fitter/Dispenser Endorsement License

3. Previous Licensure or Certification

List all states where licenses are or were held. (Previous credential to include license, certification or registration.) Specifically list all licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if certificate(s) or license is current.

STATE/JURISDICTION	LICENSE NUMBER	ACTIVE / INACTIVE	EXPIRATION DATE (MO/DAY/YR)

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Agent Registration (Contact Person)

Pursuant to RCW 18.35.230, each license holder shall name a registered agent to accept service of process for any violation of this chapter or rule adopted under this chapter. This registered agent can be the owner or manager of the business; your attorney; or someone who will accept the responsibility of receiving legal documents should you not be available to accept them.

The registered agent may be released at the expiration of one year after the license issued under this chapter has expired or been revoked if no legal action has been instituted against the license holder.

Name of Registered Agent _____

Address _____

City _____ State _____ Zip _____

6. Education

In the spaces below, provide a chronological listing of your educational preparation and post-graduate training. (Attach additional 8 1/2 X 11 sheets if necessary.)

FULL NAME, CITY AND STATE SCHOOLS ATTENDED	DEGREE EARNED	ATTENDANCE	
		ENTRANCE DATE	ENDING DATE

7. Bonding Requirement

RCW 18.35.240 Every establishment engaged in the fitting and dispensing of hearing instruments shall file with the department a surety bond in the sum of ten thousand dollars, running to the state of Washington, for the benefit of any person injured or damaged as a result of any violation by the establishment's employees or agents of any of the provisions of this chapter or rules adopted by the director.

In lieu of the surety bond required by this section, the establishment may file with the department a cash deposit or negotiable security acceptable to the department.

I, _____ , do hereby certify that I am covered by
APPLICANT'S NAME

Security Bond Number _____ , with _____ ,

Surety Company, whose Agent is _____ at

_____ _____ _____
AGENCY ADDRESS CITY STATE

_____
ZIP

_____ _____
SIGNATURE OF APPLICANT DATE

8. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

9. Applicant's Attestation

I, _____ , certify that I am the person described and
NAME OF APPLICANT
identified in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in th State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Out of State Verification of Certification/Licensure As A Hearing Instrument Fitter and Dispenser

To Applicant:

Please complete this section. Forward this form to the jurisdiction of certification/licensure for them to complete and return to Department of Health, Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869.

I, _____ , am certified/licensed in the state of _____ ,

my certificate/license number is _____ . I have applied for a Washington State Hearing Instrument Fitter/Dispenser Program. I authorize the release of the information request below to the Washington State Hearing and Speech Program.

Signature _____ Date _____

To The State Board:

Please provide **a copy of the current statute** under which the above named applicant is certified/licensed. Please return this completed form with the statute to the Department of Health, Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869. Thank you.

I hereby certify that _____ was granted professional license number _____ to practice fitting and dispensing hearing instruments in the state of _____ on the _____ day of _____ , 20 _____ .

on the basis of:

☐ Successfully passing the International Hearing Aid Society Licensing examination Yes ☐ No ☐

☐ Successfully passing the required state constructed examination:

Written: Yes ☐ No ☐

Practical: Yes ☐ No ☐

☐ Other (please explain): _____

Status of Certification/Licensure: ☐ Active ☐ Inactive ☐ Expiration Date (MO/DA/YR) _____

Legal or Disciplinary Action?: ☐ Yes ☐ No If yes, please explain below and provide any applicable documentation.

_____

_____

_____

State Seal

_____
SIGNATURE OF VERIFIER DATE

_____
TITLE OF VERIFIER

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Special Examination Requirements

If you have a disability that requires special accomodation with the written examination, please complete this form and return it with your application. If you have any questions or concerns, please write to: Hearing and Speech Program, PO Box 47869, Olympia, WA 98504-7869.

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE *(where you can be reached during normal business hours)*	DATE OF BIRTH (MO/DAY/YR)	

1. Will you require an Oral Translator? ☐ Yes ☐ No

   If YES, for what Language? _____

2. Do you have a condition requiring special attention? ☐ Vision Problems ☐ Physical Disability ☐ Learning Disability

   ☐ Other (specify) _____

3. What special services will you need? _____

Note: If requesting extra time, a reader, or a writer for learning disabilities, you must have your physician, optometrist, learning specialist, etc., complete the bottom section of this form.

SIGNATURE OF APPLICANT	DATE

To the Physician, Optometrist, Learning Specialist, Etc.

Please complete the following section regarding the candidates for the licensing/certification examination.

Applicant's Name _____

requires the following special needs for the written portion of the licensure/certification examination.

☐ Extra Time ☐ Reader ☐ Writer

YOUR NAME (PLEASE TYPE OR PRINT LEGIBLY)		DATE
WRITTEN SIGNATURE		DATE
ADDRESS		CITY
STATE	ZIP	TELEPHONE *(where you can be reached during **normal** business hours)*

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APPLICATION FOR HEARING INSTRUMENT FITTER/DISPENSER EXAMINATION

Please type or print clearly. It is the responsibility of the applicant to complete this application. Failure to do so could result in a delay in setting the examination date.

PART I – PERSONAL INFORMATION

Note: Type or print with black pen.

Last Name _____

First Name _____

Middle Initial or Name _____

Social Security Number _____

Address _____

City _____ State _____ Zip _____

Phone ( ) _____ E-Mail _____

PART II – DATES AND SITES OF EXAMINATION

The examination for Hearing Instrument Fitter/Dispensers will be given four times during the year 2006. Please place a checkmark in the box next to the date you wish to sit for your examination.

2006

- ❒ March 14, 2006 – Tacoma
- ❒ June 13, 2006 – Spokane
- ❒ September 12, 2006 – Tacoma
- ❒ December 5, 2006 – Spokane

Confirmation of your examination reservation will be sent to you upon receiving the application form. **APPLICATIONS MUST BE RECEIVED AT LEAST 45 DAYS PRIOR TO EXAMINATION DATE. The will be no exceptions for late applications.**

PART III – FEES FOR EXAMINATION

EXAMINATION – The fee for taking the examination is **$195.00** and must accompany your application. In the event a valid reason is given for not taking the examination on the requested date another date will be set.

Application and fees must be sent to:

INTERNATIONAL INSTITUTE FOR HEARING INSTRUMENTS STUDIES
16880 Middlebelt Road, Suite #4
Livonia, MI 48154
734-522-7200

FOR OFFICE USE ONLY

Date Received _____

Registration Fee Received _____

Date Eligibility Letter and Candidate Manual Sent _____